State of California Department of Consumer Affairs

MEDICAL BOARD OF CALIFORNIA
EXECUTIVE OFFICE
1434 Howe Avenue, Suite 92
Sacramento, CA 95825-3236
(916) 263-2389 FAX (916) 263-2387
www.medbd.ca.gov

EXHIBIT 1

February 7, 2003

Name (Name of Malpractice Carrier CEO or Specialty Society President)
Address

Dear (Name of Malpractice Carrier CEO or Specialty Society President):

Last year, legislation was passed that mandated the disclosure of certain malpractice settlement information to the public. SB 1950 (Figueroa; Chapter 1085; Statutes of 2002) requires that the Medical Board promulgate regulations to address this requirement this year, and mandates that the Board hold public meetings with the malpractice insurance carriers, health care systems that self-insure physicians, and California medical specialty societies.

On February 26, we will hold our first public meeting to discuss the requirements of this legislation, and to provide the foundation for the regulatory process. (Agenda attached.) While the law requires that the Board provide the public with certain limited information about malpractice settlements, it places certain restrictions on what and how this information may be disclosed.

In summary, for physicians who practice in a "low risk" specialty, only those physicians with three or more settlements over a period of 10 years (beginning on January 1, 2003) will have this information disclosed on their licensing record. Physicians in a "high risk" specialty will only have malpractice information disclosed if they have four or more. The actual amount of the settlements will not be disclosed, instead, the Board must disclose them by category of "below average," "average," and "above average."

In order for the Board to develop the regulations and determine the specialties at high and low risk, the law mandates that it consult with commercial underwriters of medical malpractice insurers, health care systems that self-insure physicians, and the medical specialty societies. The Board is directed to utilize the carriers' statewide data to establish the risk categories and averages.

In addition to determining specialty risk, the Board will also need assistance to develop the formula to determine the average amount of settlements for various specialties. In ten years, our Board will have the actual data on all lawsuits and specialties within that period and will be in the position to develop a statistically sound and defensible formula with limited outside assistance. At the onset of the law's implementation, however, the Board will have insufficient data to develop a formula and will need the expertise of those involved in the healthcare and malpractice insurance industries.

The Board needs your assistance in the regulatory process, and we are hopeful that you will attend the meeting on February 26. If you or a representative cannot attend, we welcome written comments on this process. Without your assistance, the Medical Board cannot move forward to implement the law. If you have any questions or comments, please feel free to call or write our office at the above address or phone number.

Sincerely,

Ron Joseph
Executive Director

Malpractice Carriers:

EXHIBIT 2

William Scheuber, CEO
Medical Insurance Exchange of California
6250 Clairmont Avenue
Oakland, CA 94618

J. William Newton, CEO
Norcal Mutual Insurance Company
560 Davis Street, Second Floor
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Donald Zuk, CEO
Southern California Physicians Insurance Exchange
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Los Angeles, CA 90067

Mark Gorney, M.D.
The Doctor's Company
P.O. Box 2900
Napa, CA 94558-0900

James Weidner, CEO
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333 So. Hope Street, 8th Floor
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Larry Shea, Managing Partner
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University of California:

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UC Regents, Office of Health Affairs
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Medical Societies:

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Christine Keeling, M.D., Chapter President
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Erno Gyetvai, M.D., President
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Jamshid Maddahi, M.D., Chapter President
Society of Nuclear Medicine, Southern California Chapter
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Los Angeles, CA 90036

Barbara Baldwin, Executive Director
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Also:

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FEBRUARY 26, 2003

PUBLIC MEETING ON PUBLIC DISCLOSURE OF MALPRACTICE SETTLEMENTS IN COMPLIANCE WITH SB 1950 (FIGUEROA; CHAP. 1085; STATS. OF 2002)

This public meeting is mandated by Business & Professions Code Section 803.1 (e)

STAFF

Janie Cordray
(916) 263-2389
(916) 263-2387 (fax)
jcordray@medbd.ca.gov

MEDICAL BOARD OF CALIFORNIA
GREG GORGES CONFERENCE ROOM
1424 Howe Avenue, Room F
Sacramento, CA 95825
(916) 263-2389

AGENDA

10:00 a.m. – 12:00 p.m.

1. Opening Remarks - Ron Joseph, Executive Director
2. Overview of what the law requires and the regulatory process - Janie Cordray, Research Director
3. Discussion of approach and data availability
4. Conclusion and discussion of next steps - Mr. Joseph
5. Adjournment

Public comment will be taken throughout the discussions.

The mission of the Medical Board of California is to protect healthcare consumers through the proper licensing and regulation of physicians and surgeons and certain affiliated healthcare professions, and through the vigorous, objective enforcement of the Medical Practice Act.

Meetings of the Medical Board of California are open to the public except when specifically noticed otherwise in accordance with the Public Meetings Act. For those unable to attend the meeting who wish to provide comments, correspondence may be sent to the attention of Janie Cordray at the above address, fax, or by e-mail.

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For additional information call (916) 263-2389.

State of California Department of Consumer Affairs

Medical Board of California

April 14, 2003 **EXHIBIT 4**

To: Ron Joseph
Executive Director

From: Janie Cordray
Research Director

Subject: **Board Action Required for Compliance with SB 1950 Provisions Relating to Public Disclosure of Malpractice Settlement Information**

Following our public meeting on February 26 for the implementation of this legislation, it is evident that the Medical Board cannot meet the mandated goal of adopting regulations relating to information disclosure through the routine rulemaking process by July 1, 2003. Emergency regulations will be needed, and, in addition, it would appear that some kind of temporary regulations to cover a transitional period will be required.

The law:

In summary, the Board must now provide the public with certain limited information about malpractice settlements. While the Board routinely receives information on settlements and lawsuits of various amounts, the law places certain restrictions on what and how this information may be disclosed.

For physicians who practice in a "low risk" specialty, only those physicians with three or more settlements over a period of 10 years (beginning on January 1, 2003) will have this information disclosed on their licensing record. Physicians in a "high risk" specialty will only have malpractice information disclosed if they have four or more. The actual amount of the settlements will not be disclosed, instead, the Board must disclose them by category of "below average," "average," and "above average."

Regulations must be promulgated to address the risk categories and the method of reporting the settlements to the public (average, below, above). To make these determinations, we must meet publicly with the interested parties, and must use the data of the major malpractice carriers in California. Regulations must be adopted by July 1, 2003.

Problem:

As the law requires, Board staff sent invitations to the CEOs of all major medical malpractice insurers and specialty societies, as well as CMA, the trial lawyers, and the UC. The invitational letter outlined the law and its requirements, and asked that they attend the meeting, send a representative, or send a written response. Attendance of the meeting was modest --- only one malpractice carrier and two specialty societies were represented, as well as the California Medical Association and Senator Figueroa's office. (The malpractice carrier representatives were its legal counsel and lobbyist, neither of whom could speak to the question of data availability or willingness of their company to provide it.)

Those in attendance voiced their willingness to work with the Board to analyze and cooperate with data when possible. While the participation of the specialty societies, the CMA, and the Senator are welcome, in order to do our job, malpractice data from the major carriers are needed. Without them, there will be no implementation of the law as envisioned by its author.

As you know from the discussions at the meeting, there appears to be logistical and practical problems with existing data. Sandra Bressler of the California Medical Association has graciously agreed to gather the data from the carriers, but it appears to be in no uniform format. Actuarial methods of determining premiums only use specialty as one factor, and it will not be an easy task to make the determination of high and low risk specialties. Ms. Bressler will be meeting with us on April 30, and will bring the data that she could obtain from the malpractice carriers. To date, I have received no written response from any malpractice carrier.

Solution:

Logistically, even if we had the data today, and we held public hearing outside of our regularly scheduled Board meetings, it would be near impossible to adopt regulations by July 1, 2003 through the routine rulemaking process. Emergency regulations will be needed. In addition, given the lack complete of data, it would appear that we need some kind of temporary regulation to allow the Board to disclose available data to the public by the mandated date. For that reason, the following are possible options to the Board:

<u>Option 1:</u>

Begin the routine regulatory process when complete data is available.

Pros:

- Staff work would be easier, and whatever is adopted will be complete and more likely to be approved by the Office of Administrative Law.
- All affected parties would have ample time to comment on the proposed regulations.
- Regulations approved in a lengthy, routine regulatory process would likely prevail legal challenges.

Cons:

- Consumers would not have settlement information until at least 2004.
- The Board would be in violation of the law.

Option 2:

Do not adopt regulations, instead, begin disclosing all settlements, as outlined in the Board's public disclosure policy adopted in 2002, prior to the passage of SB 1950.

Pros:

- More information would be made available to consumers.
- Would be easy and cheap to implement, as the Board could simply post the information it receives from the 800 reports.

Cons:

- Would not comply with the mandate of SB 1950, and therefore the Board would be violating the law.
- Would likely be legally challenged, and the Board would most certainly not prevail.

Option 3:

Promulgate emergency regulations to disclose settlements, based on available data, with a sunset date in 2004. By that time, hopefully, all of the data envisioned by the proponents of this legislation will be fully available and useful, and permanent regulations may be promulgated through the regular rulemaking process.

Pros:

- Some information would be made available to consumers.
- While any disclosure regulation will be contentious, knowing that this action would be a temporary solution, it would allow stakeholders an opportunity to comment on not only the temporary regulations, but time to weigh-in on the permanent regulations.
- The legally mandated deadline can be met (or at least met more closely).
- This action is less likely to invite legal challenge in comparison to the other options.

Cons:

- Temporarily, the information given to the consumer will not be what was envisioned by the bill's author.
- It may be difficult to gain the approval of temporary regulations by the Office of Administrative Law. (Such a proposal has never been tried before by the Board.)

Discussion:

Obviously, I would recommend Option 3, although this does require more staff work. Quite frankly, there is no other option that I can foresee that would meet at least the spirit of the law's desire to disclose more information to consumers. Without data, the Board cannot comply with the law as written. For that reason, I would recommend that we move forward with some type of temporary regulations that may be used in this interim period of "low-data-land."

While there is little data, there is some. The National Practitioner Data Bank publishes an annual report, which outlines the number and average amounts of settlements by state. While that would not give us specialty information, we can, to prevent legal challenge, grant everyone "high risk" specialty status until we have defendable data. Certainly, there is no defensible argument against disclosing four or more settlements. The law mandates at least that. In addition, we could either use the total settlement information from the Data Bank, or use the reports received by the Board to determine the low-average-high amounts, which could be changed as more data is received. (In addition, a private foundation that tracks verdicts and settlements, LRP, the publisher of "Jury Verdicts," has some information that may be useful.)

Option 3 is not a good solution, but as I see it, it is the only solution. Unless the Board is willing to approach the Legislature to ask for an amendment of the law to extend the deadline, I see no other option. If you have any other ideas, let me know. If we are to go with emergency temporary regulations, after we meet with Ms. Bressler on the 30th, we will need to have legal counsel draft the language so that notices may be mailed quickly.

State of California Department of Consumer Affairs

Medical Board of California

July 11, 2003 **EXHIBIT 5**

To: Members,
Division of Medical Quality

From: Janie Cordray
Research Director

Subject: **Board Action Required for Compliance with SB 1950 Provisions Relating to Public Disclosure of Malpractice Settlement Information**

As reported to the members at their last meeting, the Board is unable to meet the mandated goal of adopting regulations relating to information disclosure through the routine rulemaking process by July 1, 2003. While unable to meet the adoption deadline, staff is moving forward as quickly as possible to develop regulatory language and a defendable methodology to establish the criteria for information disclosure of malpractice settlements.

The law:

In summary, the Board must now provide the public with certain limited information about malpractice settlements. While the Board routinely receives information on settlements and lawsuits of various amounts, the law places certain restrictions on what and how this information may be disclosed.

For physicians who practice in a "low risk" specialty, only those physicians with three or more settlements over a period of 10 years (beginning on January 1, 2003) will have this information disclosed on their licensing record. Physicians in a "high risk" specialty will only have malpractice information disclosed if they have four or more. The actual amount of the settlements will not be disclosed, instead, the Board must disclose them by category of "below average," "average," and "above average."

Regulations must be promulgated to address the risk categories and the method of reporting the settlements to the public (average, below, above). To make these determinations, the Board is mandated to meet publicly with the interested parties, and must use the data of the major malpractice carriers in California.

Problem:

As the law requires, Board staff sent invitations to the CEOs of all major medical malpractice insurers and specialty societies, as well as CMA, the trial lawyers, and the University of California. The invitational letter outlined the law and its requirements, and asked that they attend the public meeting on February 26, send a representative, or send a written response. Attendance of the meeting was modest --- only one malpractice carrier and two specialty societies were represented, as well as the California Medical Association and Senator Figueroa's office. (The malpractice carrier representatives were its legal counsel and lobbyist, neither of whom could speak to the question of data availability or ability of their company to provide it.)

Those in attendance voiced their willingness to work with the Board to analyze and cooperate with data when possible. While the participation of the specialty societies, the CMA, and the Senator are welcome, in order to do our job, malpractice data from the major carriers is needed. Without their participation, the law cannot be implemented in the manner envisioned by its author.

From the discussions at the meeting, there appears to be logistical and practical problems with existing data. Sandra Bressler of the California Medical Association graciously agreed to gather the data from the carriers, but it appears to be in no uniform format. Actuarial methods of determining premiums only use specialty as one factor, and it is not an easy task to make the determination of high and low risk specialties. To date, I have received no written response from any malpractice carrier.

Solution:

Given the lack of more current uniform data from the malpractice carriers, the Board must move forward with the information it has. Thankfully, due to the legally mandated reporting requirements established in the 1970s and 1980s, the Medical Board has been receiving reports of settlements for well over 10 years. Practically speaking, these reports are not ideal for our present purpose, but they do contain much of the data needed for analysis, as they contain the amount of the settlement and the date. Absent from the reports is the specialty information, including practice and board-certification status. Through other sources, by accessing the AMA physician data base and manually reviewing the reporting forms, this information can be obtained in about 90% of the reports. For this reason, staff is manually compiling the absent information and will calculate the specialty risk and payment averages by hand. While tedious, it is possible --- and it is the only workable solution at this time.

Proposed Regulation:

Staff is proposing that a regulation hearing be scheduled for the November meeting of the Division of Medical Quality. This regulation, as staff proposes, would contain the following concepts:

Categorizing High & Low Risk Specialties:

While the staff is still compiling the data, which will be hand-carried to the DMQ meeting on August 1, it would appear, based on preliminary calculations, that there are approximately six specialties that are of a higher likelihood of reflecting malpractice settlements and are eligible to be considered "high risk" on a purely comparative basis. Other specialties appear to be at approximately the same low risk. Staff will be working with legal counsel to determine whether the regulations should specifically list the specialties in the regulatory language, provide a formula method used, or allow for yearly adoption of the "high risk" specialties by the DMQ.

"Below Average,""Average," and "Above Average" - Method of Reporting of Settlements:

The assignment of "below, average, and above" will be assigned mathematically, using the following formula:

Mean average of total reports from January 1 to date will be calculated. Based on that number, the categories will be figured as follows:

Average: 16% above and below the mean
Above Average: 17% and above the mean
Below average: 17% and below the mean

It is proposed that the average will be calculated annually to determine the designation to be assigned to any records added to the website for that calendar year.

Action of the DMQ:

At the August DMQ meeting, staff will ask the members permission to move forward in promulgating regulations based on available data. At that time, staff will have completed manually compiling the data from existing Board reports and will present it to the members. Staff will further ask the members' permission to schedule a regulatory hearing for the November 2003 DMQ meeting, with language based on the above mentioned concepts.

The advantage of moving forward with the regulatory process is twofold. First, *if* the data compiled by the Board from existing reports is significantly inconsistent with the malpractice industry's, we can expect to hear from them and will receive more complete data. (It would further tell us that the previous reporting system is flawed and inaccurate.) The regulatory process is one that encourages participation and the furnishing of defensible data. Secondly, it will allow the Board to meet the spirit of the legal mandates contained in SB 1950 (Figueroa) more quickly than awaiting more information which may not even be available. The process provides ample time and a forum for the industry to share and comment on the Board's proposal.

While it is likely that additional defining regulations will be needed in the future relating to more detailed criteria for disclosure calculations and possibly criteria for review and appeal

procedures, the basic, minimum regulation would allow the Board to provide more information to the public more quickly. For this reason, it would appear that the Board should immediately move forward with the rulemaking process.

Ron Joseph, Anita Scuri, and I will be attending the August DMQ meeting and will be available for questioning. In the meantime, if you have any questions or suggestions, feel free to contact me at 916-263-2389.

State of California Department of Consumer Affairs

Medical Board of California

July 28, 2003 **EXHIBIT 6**

To: Members,
Division of Medical Quality

From: Janie Cordray
Research Director

Subject: **Follow-up to July 11, 2003 Memorandum (in members' packets); Data compiled relating to physician malpractice settlements in the past 10 years**

As promised in the July 11, 2003 memorandum, staff has manually compiled and analyzed the data received from malpractice insurers over the past ten years.

As explained in that memo, because the data that was available to the Board from the insurers was of little use as it related to the establishment of public information disclosure mandated in SB 1950 (Figueroa), staff has compiled the data it has received over the past ten years through the mandated reports filed under B&P Code Section 800 (et seq.).

Good News/Bad News:

While we have the data, a number of assumptions must be made about it in order to categorize it. The reports received in 1993 through 2002 contained settlement information, without specialty designation.

There are a number of sources to determine the practice specialty of the physician who settled malpractice suits. The AMA database reports physicians' specialty and board certification, and the ABMS reports the number of certified specialists in the state. The Medical Board database contains the number of licensed physicians residing in California, but does not report specialty, or even clinical practice (some may be administrators or in other non-clinical positions or completely out-of-practice). The reports and our enforcement files often summarize the subject of the lawsuit. For this reason, staff made use of all of those sources, and it is our belief that the assumptions made are reasonable and workable.

Crunching the numbers:

Specialty Determination:

Specialty was determined by a number of sources. The AMA database contains physicians' stated practice specialty, as well as board certification, which is also a part of the ABMS database. All physicians with three or more settled suits from 1/1/1993 to 12/31/2002 were run through such databases. If there was no record from those sources, enforcement records were reviewed to determine the area of specialty the physician was practicing at the time of the settlement and the facts surrounding the case.

Number of physicians and numbers in specialty:

The assumption was made that over a period of 10 years, approximately 120,000 physicians were licensed to practice in California. This assumption is made by the number of new physician licenses issued each year and the number of total licensees for each year. The percentage of the total number of physicians in each specialty was determined by ABMS records of number of certified specialists in California, which gave us the percent of the total number of specialties represented. This percentage was multiplied by the 120,000 total to estimate the number of specialists practicing in California for the 10 year period.

The number of physicians who settled cases:

There was no assumption needed for this figure. The numbers on the following chart were based on all of the reports received during the period of 1/1/1993 to 12/31/2002:

10 Year Data Received - 1/1/93 through 12/31/2002
Physicians with Three or More Malpractice Settlements

Specialty	# of physicians with 3 or more settlements in 10 years.	Estimated Total of Physicians in California, by Specialty, in Ten years. (Percentage of total population)	Percentage of Physicians with three or more settlements, per specialty in 10 years.	Ratio
All specialties	**375**	**120,000 (100%)**	**0.3125%**	**1:320**
Anesthesiology	7	5,040 (4.2%)	0.13888%	1:720
Dermatology	11	1,800 (1.5%)	0.6111%	1:164
Emergency	7	5,400 (4.2%)	0.12962%	1:771
Family Practice	14	9,000 (7.5%)	0.15555%	1:642
Internal Medicine	25	25,200 (21%)	0.0992%	1:1008
Neurosurgery	**21**	**600 (0.5%)**	**3.5%**	**1:29**
Neurology	6	1,560 (1.3%)	0.38461%	1:260
Obstetrics/Gynecology	68	8,400 (7%)	0.80952%	1:124
Ophthalmology	11	3,000 (2.5%)	0.36666%	1:273
Orthopaedic Surgery	**69**	**4,080 (3.4%)**	**1.69117%**	**1:59**
Otolaryngology	7	1,560 (1.3%)	0.44871%	1:223
Pathology	2	3,000 (2.5%)	0.06666%	1:1500
Pediatrics	4	12,360 (10.3%)	0.03236%	1:3090
Plastic Surgery	**30**	**1,200 (1%)***	**2.5%**	**1:40**
Psychiatry	1	5,520 (4.6%)	0.01811%	1:5520
Radiology	18	5,400 (4.5%)	0.33333%	1:300
General Surgery	50	6,480 (5.4%)	0.7716	1:130
Cardiothoracic Surgery	11	1,200 (1%)	0.91666	1:109
Urology	13	1,800 (1.5%)	0.72222%	1:138

* Board Certified Plastic Surgeons only make up approximately .75%, but there are others who are members of other Cosmetic Surgery Societies, and therefore it was rounded to 1%

Out of the above numbers, we extracted only those physicians who had 4 or more settlements — those results are even more interesting:

10 Year Data Received - 1/1/93 through 12/31/2002
Physicians with Four or More Malpractice Settlements*

Specialty	# of settlements	# of physicians	Breakdown of # of settlements per doctor
Total	748	121	see below
Urology	124	8	1 dr. with 80 1 dr with 15 2 drs. with 6 1 dr. with 5 3 drs. with 4
Plastic Surgery	116	15	1 dr. with 35 1 dr. with 14 3 drs. with 7 1 dr. with 6 4 drs. with 5 5 drs. with 4
Neuro-surgery	87	12	1 dr. with 27 1 dr. with 12 1 dr. with 8 1 dr. with 7 1 dr. with 5 7 drs. with 4
Ophthal-mology	46	7	1 dr. with 12 1 dr. with 10 1 dr. with 8 4 drs. with 4
Ortho-paedic Surgery	116	23	1 dr. with 9 1 dr. with 8 2 drs. with 7 2 drs. with 6 5 drs. with 5 12 drs. with 4
General Surgery	81	17	1 dr. with 8 1 dr. with 7 6 drs. with 5 9 drs. with 4
OB/ GYN	113	24	1 dr. with 8 1 dr. with 7 2 drs. with 6 6 drs. with 5 14 drs. with 4

Specialty	# of settlements	# of physicians	Breakdown of # of settlements per doctor
Cardio-thoracic Surgery	14	3	1 dr. with 6 2 drs. with 4
Gastroen-terology	5	1	1 dr. with 5
General Family Practice	5	1	1 dr. with 5
Derm-atology	5	1	1 dr. with 5
Internal Medicine	12	3	3 drs with 4
Otolaryn-gology	4	1	1 dr. with 4
Anesthe-siology	4	1	1 dr. with 4
Psychiatry	4	1	1 dr. with 4
Radiology	8	2	2 drs. with 4
Emergency	4	1	1 dr. with 4

* Numbers in this chart are included in the table on page 3, as physicians with three or more settlements.

Gaining Perspective:

As the charts show, there are only three specialties that have greater than 1% of the specialists who settled three or more malpractice cases. How can that be? Aren't all surgeons and Obstetricians/Gynecologists at high risk of lawsuit? The short answer is yes, but the complete answer for our purposes needs further analysis.

Remember, SB 1950 only pertains to the disclosure of three or more settlements paid in a 10-year period. While a physician may face the *filing* of many lawsuits, few result in payment to the plaintiff. According to *Medical Malpractice Danger Zones, Medical Economics* (August 24, 1998, based on PIAA data), 62.9% of all claims filed from 1985 to 1998 were dropped or dismissed without payout, only 30.4% of all claims resulted in a settlement with payment, and only 1.3% of cases resulted in a jury award.

According to the Medical Board's malpractice settlement data, during the 10-year period from 1/1/1993 to 12/31/2002, there were only 1580 physicians that had settled two or more malpractice suits. If we are correct that there were approximately 120,000 physicians practicing in California during that time, only 1.3% of all physicians settled two or more claims. That's not to say that plaintiffs' lawyers weren't busy filing suits, defense attorneys weren't busy responding, and doctors weren't made anxious at the prospect of a trial, the suits just rarely resulted in any payment to the filing party.

To put this in perspective, in the last six months, based on the reports <u>received</u>, *there would only be TWO* physicians who qualify for the disclosure of settlement data. Both physicians are in surgical specialties, one settling 7 suits and the other settling 5 in the past 6 months. There are no others with even three settlements in that period of time. After complete review of the reports, there would *only be the ONE physician who would have settlements disclosed at this time*. Although the report on the physician with 7 settlements was received during the past 6 month period, the cases were settled before 2003, and therefore cannot be disclosed.

To illustrate, the chart that follows contains the Board's first six month data received for this year, January through June.

6 Month Data Received - 1/1/03 through 6/24/03
All Malpractice Settlements Reported

Specialty	# of Settlements	# of Physicians
Opthalmology	22	15; out of which: 1 doctor with 7, 1 doctor with 2
Neurosurgery	5	1 (One doctor for all 5)
General/Family Practice	82	80; out of which: 2 doctors had 2
Orthopaedic Surgery	24	23; out of which: 1 doctor had 2
Radiology	20	19; out of which: 1 doctor had 2
Anesthesiology	27	25; out of which: 2 doctors had 2
General Surgery	88	87; out of which: 1 doctor had 2
Cardiology	15	15
Dermatology	2	2
Emergency Medicine	31	31
Internal Medicine	39	39
Gastroenterology	3	3
Neurology	6	6
Obstetrics/Gynecology	74	74
Oncology	2	2
Otolarangology	8	8
Pathology	3	3
Pediatrics	22	22
Plastic Surgery	11	11
Psychiatry	5	5
Urology	6	6
Total	495	477; out of which 10 had multiple settlements, as follows 1 had 7 1 had 5 8 had 2 467 had 1

As you can see from the chart, almost all of the physicians who have settled cases

have only one settlement, with only 10 having reported multiple settlements. Regardless of "high or low" risk specialty, based on the above, there would be only two physicians that would have settlements disclosed to the public. Also, improved reporting requirments result in more discreet reporting data.

After doing a more thorough review of the reports received - Enforcement staff read each and every report to determine whether the suit was actually settled before or after 2003. Based on the settlement date, the following were settled after the 2003 threshold:

Specialty	# of Drs.	Total $	Average$
Oncology/ Hematology	2	1,202,500	601,250
Gastroenterology	3	1,755,999	591,667
Psychiatry	5	2,485,000	497,000
Neurology	4	1,599,723	399,931
Neurosurgery	10	3,595,000	359,000
Neuroradiology	1	350,000	350,000
Thoracic Surgery	5	1,715,362	343,072
Pediatrics	15	5,043,500	336,233
Emergency	16	4,911,332	306,958
Anesthesiology	19	5,504,627	289,717
Internal Medicine	27	7,668,928	284,034
OB/GYN	40	11,190,126	279,753
Ophthalmology	8	1,950,000	243,750
Cardiology	16	3,806,758	237,923
Neonatology	3	670,000	223,333
Pathology	3	645,000	215,000
Family/General Practice	31	6,222,447	200,724

Specialty	# of Drs.	Total $	Average $
General Surgery	27	5,926,334	196,161
Orthopedics	20	3,490,327	174,516
Radiology	13	2,015,500	155,038
Otolaryngology	12	1,784,930	148,744
Plastic Surgery	12	1,755,999	146,333
Urology	2	265,000	132,500
Dermatology	1	125,000	125,000
Critical Care	1	100,000	100,000
Physical Medicine	1	40,000	40,000

The Task at Hand:

High & Low Risk Specialties:

The law requires that for physicians who practice in a "low risk" specialty, only those physicians with three or more settlements over a period of 10 years (beginning on January 1, 2003) will have this information disclosed on their licensing record. Physicians in a "high risk" specialty will only have malpractice information disclosed if they have four or more. It is the Board's responsibility to determine, based on malpractice industry data (reports of payment are submitted by malpractice carriers), which specialties should be considered "high" and "low" risk.

Reviewing the numbers in the previous chart, it would appear that no specialty is at particularly high risk, but there are those with higher risk than others. There are only three specialties with a risk greater than 1% of three suits or more, which are, Neurosurgery, Orthopaedic Surgery, and Plastic Surgery. Since the law does not require the Board to determine "high risk" as a comparative value, it is possible for a determination to be reached that there are no high risk specialties for purposes of settlement reporting.

"Average," "Above Average," and "Below Average" - Reporting the Settlement:

The actual amount of the settlements will not be disclosed, instead, the Board must disclose them by category of "below average," "average," and "above average." As explained in the July 11 memorandum, staff would propose the following formula:

> Mean of total reports from January 1 to date will be calculated. Based on that number, the categories will be figured as follows:
>
> > Average: 16% above and below the mean
> > Above Average: 17% and above the mean
> > Below average: 17% and below the mean

It is proposed that the average will be calculated annually to determine the designation to be assigned to any records added to the website for that calendar year.

DMQ Action at August 1, 2003 meeting:

Staff would ask the members' direction to allow for the promulgation of regulations based on available data. This is the most logical step, as the rulemaking process invites public comment and will allow the malpractice insurance carriers and specialty

societies to either endorse this system or to provide additional data they may wish to assert as more reliable. If the Board is to make reasonable progress in meeting the mandates of SB 1950 (Figueroa), then the process must begin before the next meeting of the DMQ so that a regulatory hearing may be held in November. (If the process is delayed, a regulatory hearing would not be scheduled until February 2004.)

The malpractice insurers and specialty societies will be invited to participate in the regulatory process and it is hoped they will be a part of the discussions. Ron Joseph, our legal counsel, Anita Scuri, and I will be at the August DMQ meeting to answer the members' questions. In the meantime, if you have any questions or suggestions, please feel free to contact me by phone at 916-263-2389, or by e-mail at jcordray@medbd.ca.gov.

Exhibit 7

California Medical Association
221 Main Street, P.O. Box 7690, San Francisco, CA 94120-7690 • (415) 541-0900
Physicians dedicated to the health of Californians

July 30, 2003

To: Ron Joseph

From: Sandra E. Bressler
Vice President, Medical and Regulatory Policy

Re: Specialty Risk Classification

Please find attached a document that divides 66 medical specialties and sub-specialties into three risk categories. This represents an amalgamation of data on risk classification of specialties from four major malpractice carriers who operate in California. I will bring copies of this document to share with the Board at the upcoming Medical Board meeting.

There are numerous analytical difficulties with this data.

The risk classifications represent a combined assessment of frequency and severity of claims for each specialty. Thus, while there may be fewer claims against an individual neurosurgeon than against an individual physician in another specialty, the severity is on average greater such that neurosurgeons fall in a higher risk category. At the same time, there are many fewer neurosurgeons, compared to other specialties. Thus, one individual neurosurgeon may likely have a higher number of claims than an individual in a specialty that has many more physicians because the neurosurgeon may get all or most of the cases (and therefore a higher likelihood of claims) in his/her locale while the cases/claims are spread wider among other specialties. All of this points to the problem of attempting to judge a physician's quality by looking at claims data in the first place.

Another major difficulty in using risk classifications to distinguish actual risk by specialty is that the frequency and severity of claims differs enormously depending on where a physician practices. The carriers deal with this issue by charging higher premiums to physicians located in Southern California than in Northern California. Most carriers have premium differences for five or six different regions, however, roughly speaking, Southern California premiums are between 66% and 77% higher than Northern California premiums. That means that simple disclosure of the number of settlements for physicians will likely seriously disadvantage physicians from Southern California in so far as consumers do not take this significant regional discrepancy into account. We would certainly recommend that serious attention be paid to mitigating this inequity.

There are limitations to amalgamating the data.

Not all carriers classify specialties as listed in this document. For example, only one carrier has classified "Aviation Medicine." The same is true of "Public Health" and "Hyperbaric Medicine." It was not difficult to determine in which of the three risk groups to place these specialties

Specialty Risk Categories
(4 Malpractice Carriers Amalgamated)

Lowest Risk	Medium Risk	Highest Risk
Administrative Medicine	Cardiology subsets	Family/General Practice with OB
Allergy and Immunology	with angio, cath & transluminal procedures	Ob/Gyn
Anesthesia (One carrier = medium)	pediatric	Surgery subsets
Aviation Medicine	with radiation	Colorectal
Cardiology w/o Cath or Angio (non-invasive)	Dermatology with liposuction	Dermatology w/ elective cosmetic
Critical/Urgent Care Medicine	Family/General Practice w/ minor or under 5%	General
Dermatology w/o lipo or elective cosmetic	surgery	Gynecology w/ cosmetic
Endocrinology	Emergency Medicine	Hand
Family/General Practice no/minor surgery	Gynecology subsets	Neurosurgery
Gastroenterology	only Gyn	Oral/Max
Hematology	only infertility	Otolaryngology with elective cosmetic
Hospitalist	Industrial Medicine	Orthopedic
Hyperbaric Medicine	Neonatology/Perinatology	Plastic
Independent Medical Examiner	Neurology	Thoracic
Infectious Disease	Ophthalmology subsets	Trauma
Industrial Medicine w/o cath or angio	with refractive surgery	Urological
Internal Medicine - non-cardiology	with elective plastic surgery	Vascular/Cardio
Medical Oncology	Radiology subsets	
Nephrology	oncology	
Occupational Medicine	w/ transluminal procedures	
Ophthalmology w/o cosmetic or refractive surg	diagnostic	
Otolaryngology w/o cosmetic surgery		
Pathology		
Pediatrics		
Preventive Medicine		
Psychiatry		
Public Health		
Pulmonary Medicine		
Rheumatology		
Radiology subsets		
reading film only		
diagnostic, right heart only		
w/o coronary procedures		
nuclear medicine		
no ultrasound		